Appendix 7

Avoiding Common Denials

Some common denial codes from claims, and the appropriate solutions for these denials, are shown in the box below.

Explanation of Benefit Code (Denial Code)	Correction
100- Claim previously/partially paid on 24XXXXXXXXXX on Remittance Advice date 02XXXX. Adjust paid claim.	Review paid claim and adjust appropriately.
399- Date of service must fall between the prior authorization grant and expiration date.	Review date of service on claim. Does it fall between the grant and expiration date on the prior authorization (PA)? If dates of service are from two PAs, you must split bill each with the correct PA number (only one PA number is allowed per claim).
970-Personal care in excess of 50 hours per calendar year requires PA.	PA is required for hours billed and paid in excess of 50 per calendar year.
322- Service(s) denied/cutback – the maximum PA service limitation frequency allowance has been exceeded.	The numbers of hours for the PA listed on the claim have been used up. If you have received an approved PA for more hours, bill with the correct PA number.
010- Recipient is eligible for Medicare.	Use the appropriate Medicare disclaimer code or attach Medicare EOB if Medicare paid.
388- Incorrect or Invalid type of service, National Drug Code or procedure code.	Enter the correct procedure code in Item 44.
652- Denied supervisory visit for unskilled cases allowed once per 60 days.	Supervisory visit only allowed once per 60 days using procedure code W9906.
398- PA number submitted is missing or incorrect.	Enter the correct seven-digit PA number in Item 63.
281- Recipient Wisconsin Medicaid identification number is incorrect.	Enter the correct 10-digit Medicaid ID number in Item 60 of the UB-92 Claim Form. Verify correct Medicaid ID number with one of the eligibility resources available.
614- Recipient's first name does not match number.	Enter recipient's name, as it appears on your eligibility file, in Item 12 of the UB-92 Claim Form. Verify name with one of eligibility resources available.
172- Recipient not eligible for date of service.	Verify recipient's eligibility with one of the eligibility resources available.
171- Claim/adjustment received after 12 months from the date of service.	See the All-Provider Handbook for late billing exceptions.